DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED
HEALTH CARE FINANCING ADMINISTRATION OMB NO. 0938-0193

OFFICIAL FILE COPY

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: HEALTH CARE FINANCING ADMINISTRATION	1. TRANSMITTAL NUMBER: **03-19**	2. STATE **Louisiana**
	3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES	4. PROPOSED EFFECTIVE DATE **April 1, 2003**	

5. TYPE OF PLAN MATERIAL (Check One):

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ■ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)

6. FEDERAL STATUTE/REGULATION CITATION: **42 CFR 431.52 and 447 Subpart C**	7. FEDERAL BUDGET IMPACT: a. FFY **2003** **($379.53)** b. FFY **2004** **($779.86)**
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: **Attachment 4.19-A, Item 1, Page 10**	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): **Same (TN 00-19)**

10. SUBJECT OF AMENDMENT: **The purpose of this amendment is to reduce the reimbursement for inpatient services provided in out of state hospitals and to amend the reimbursement for children's hospitals located in states bordering Louisiana. This action is necessary in order to avoid a budget deficit in the medical assistance programs.**

11. GOVERNOR'S REVIEW (Check One):

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
■ OTHER, AS SPECIFIED: **The Governor does not review state plan material**

12. SIGNATURE OF STATE AGENCY OFFICIAL: David W Hood	16. RETURN TO: **State of Louisiana** **Department of Health and Hospitals** **1201 Capitol Access Road** **PO Box 91030** **Baton Rouge, LA 70821-9030**
13. TYPED NAME: **David W. Hood**	
14. TITLE: **Secretary**	
15. DATE SUBMITTED: **June 24, 2003**	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: JUN 26 2003	18. DATE APPROVED: JAN - 5 2004

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: APR - 1 2003	20. SIGNATURE OF REGIONAL OFFICIAL: Brown for Smith
21. TYPED NAME: Charlene Brown	22. TITLE: Deputy Director, CMSO

23. REMARKS:

RECEIVED
JUN 26 2003
REGION VI-DALLAS
HCFA/MOFMB

FORM HCFA-179 (07-92)

PAYMENT FOR MEDICAL AND REMEDIAL CARE AND SERVICES

METHODS AND STANDARDS FOR ESTABLISHING RATES - IN-PATIENT HOSPITAL CARE

CITATION 42CFR
447.253, OBRA 90
P.L. 101-508,
Sections 4702-4703

Medical and Remedial
Care and Services
Item 1 (Cont.)

C. Out-of-State Facilities-

Effective for dates of service on or after April 1, 2003, out-of-state facilities are reimbursed for inpatient hospital services at the lower of 40% of billed charges or the Medicaid per diem rate of the state wherein the services are provided for recipients age 21 and older and the lower of 60% of billed charges or the Medicaid per diem rate of the state wherein the services are provided for recipients under the age of 21. Hospitals designated as children's hospitals that are located in states that border Louisiana shall be reimbursed at the lower of the Medicaid per diem rate of the state wherein the services are provided or the Louisiana children's hospital Medicaid peer group rate. Neonatal intensive care unit services, pediatric intensive care unit services, and burn unit services provided in these children's hospitals shall be paid the Louisiana peer group rate for the qualifying level of service documented by the hospital. The hospital stay and the level of service shall be authorized by the Bureau.

For dates of service on or after March 8, 2000, out-of state facilities that provided at least five hundred (500) inpatient hospital days in State Fiscal Year 1999 to Louisiana Medicaid recipients and are located in border cities (cities located within a fifty (50) mile trade area of the Louisiana state border) will be reimbursed at the lesser of each facility's actual cost per day or the Medicaid per diem rate of the state wherein the services are provided. The actual cost per day is calculated from each hospital's 1998 filed Medicaid cost report by dividing total Medicaid inpatient cost by total Medicaid inpatient days, including nursery days. This is a one-time determination for the inpatient days and actual costs. This reimbursement methodology is applicable for all Louisiana Medicaid recipients who receive inpatient services in an out-of-state facility located in a border city, including those recipients up to the age of twenty-one.

D. Disproportionate Share Hospitals

Effective for inpatient hospital services provided on or after July 1, 1988, a payment adjustment for hospitals serving a disproportionate share of low income patients (DSH) shall be implemented in the following manner: